	FOR OHF USE				

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2000

STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2000)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0000786	II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: VERMILION MANOR NURSING HOME Address: 14792 CATLIN TILTON ROAD DANVILLE Number City County: VERMILION	Zip Code State of and cer are true applica	re examined the contents of the accompanying report to the fillinois, for the period from 12/01/99 to 11/30/00 tify to the best of my knowledge and belief that the said contents e, accurate and complete statements in accordance with ble instructions. Declaration of preparer (other than provider)
	Telephone Number: 217-443-6430 Fax # 217-443-1558 IDPA ID Number: 37-6002224-001 Date of Initial License for Current Owners: 01/01/74	Inter	d on all information of which preparer has any knowledge. ntional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.
	Type of Ownership:	of Provider	(Signed) (Date) (Type or Print Name) EDIE HESSER
	VOLUNTARY,NON-PROFIT PROPRIETAR Charitable Corp. Individual Trust Partnersh	State X County	(Title) ADMINISTRATOR (Signed) (Data)
	IRS Exemption Code Corporati "Sub-S" C Limited L Trust Other	orp. Paid	(Print Name and Title) (Firm Name CLIFTON GUNDERSON LLP
	In the event there are further questions about this report, please contact:		& Address) 2 E. MAIN SUITE 120, DANVILLE, IL. 61832 (Telephone) 217-442-1643 Fax ‡ 217-443-5470 MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID
	Name: EDIE HESSER Telephone Number:	(217) 443-6430	201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facil	ity Name & ID Numl	ber VERMILION	N MANOR NURSIN	IG HOME			# 0000786 Report Period Beginning: 12/01/99 Ending: 11/30/00
	III. STATISTICA	AL DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/	certification level(s) of	f care; enter numbe	r of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	oeds	N/A		
	· · · ·	,	S	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							N/A
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? YES
	Report Period	Level of C	-	Report Period	Report Period		1. Does the facility maintain a daily midnight census.
	Report reriou	Level of v	care	Report 1 eriou	Report Ferrou		G. Do pages 3 & 4 include expenses for services or
1	50	Skilled (SNI	E)	50	18,250	1	investments not directly related to patient care?
2	30		atric (SNF/PED)	30	10,230	2	YES NO X
3	187	Intermediat		187	68,255	3	125
4	107	Intermediat		107	00,233	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered C				5	YES NO X
6		ICF/DD 16				6	
_		ICI7DD 10	or Less			+ •	I. On what date did you start providing long term care at this location?
7	237	TOTALS		237	86,505	7	Date started 1/01/74
				•	,		
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report per	riod.				YES Date NO X
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid	•	·			YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 17 and days of care provided 2,629
8	SNF	3,681	366	2,667	6,714	8	
9	SNF/PED					9	Medicare Intermediary
10	ICF	34,963	12,602	771	48,336	10	
11	ICF/DD					11	IV. ACCOUNTING BASIS
12	SC					12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	38,644	12,968	3,438	55,050	14	Is your fiscal year identical to your tax year? YES NO
	C P (C	(0.1	10 4.4. 30. 43. 33	4.11			T. V
		ccupancy. (Column 5, n line 7, column 4.)	63.64%	otal licensed			Tax Year: N/A Fiscal Year: 12/01/99-11/30/00 * All facilities other than governmental must report on the accrual basis.
	Deu days O		UJ.UT /0	_			An incincies other than governmental must report on the actival basis.

STATE OF ILLINOIS # 0000786 Page 3 Facility Name & ID Number VERMILION MANOR NURSING HOME
V COST CENTER EXPENSES (throughout the report places round to the persent **Report Period Beginning:** 11/30/00 12/01/99 **Ending:**

	V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)											
			Costs Per Genera	-		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	374,718	37,351	17,410	429,479		429,479		429,479			1
2	Food Purchase		284,858		284,858	(27,375)	257,483	(1,752)	255,731			2
3	Housekeeping	126,698	21,177		147,875		147,875		147,875			3
4	Laundry	92,289	13,734		106,023		106,023		106,023			4
5	Heat and Other Utilities			155,285	155,285	(283)	155,002	(4,741)	150,261			5
6	Maintenance	103,093	22,865	43,041	168,999		168,999		168,999			6
7	Other (specify):* WASTE DISPOSAL			12,991	12,991		12,991		12,991			7
8	TOTAL General Services	696,798	379,985	228,727	1,305,510	(27,658)	1,277,852	(6,493)	1,271,359			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)						9
10	Nursing and Medical Records	2,345,395	305,210	58,388	2,708,993	(18,290)	2,690,703		2,690,703			10
10a	Therapy			198,629	198,629	(2,097)	196,532		196,532			10a
11	Activities	123,835	665		124,500		124,500		124,500			11
12	Social Services	46,783	2,585		49,368		49,368		49,368			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,516,013	308,460	281,017	3,105,490	(44,387)	3,061,103		3,061,103			16
	C. General Administration					·						
17	Administrative	56,200			56,200		56,200		56,200			17
18	Directors Fees							4,169	4,169			18
19	Professional Services			13,150	13,150		13,150	3,500	16,650			19
20	Dues, Fees, Subscriptions & Promotions			12,039	12,039		12,039		12,039			20
21	Clerical & General Office Expenses	125,183	6,965	19,396	151,544		151,544	6,200	157,744			21
22	Employee Benefits & Payroll Taxes			467,535	467,535	27,375	494,910	4,687	499,597			22
23	Inservice Training & Education			2,706	2,706		2,706		2,706			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,888	2,888		2,888		2,888			25
26	Insurance-Prop.Liab.Malpractice			12,892	12,892		12,892		12,892			26
27	Other (specify):* BAD DEBT EXP			18,228	18,228		18,228	(18,228)				27
28	TOTAL General Administration	181,383	6,965	548,834	737,182	27,375	764,557	328	764,885			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,394,194	695,410	1,058,578	5,148,182	(44,670)	5,103,512	(6,165)	5,097,347			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

VERMILION MANOR NURSING HOME

#0000786

Report Period Beginning:

12/01/99

Ending:

Page 4 11/30/00

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			211,293	211,293		211,293		211,293			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,512	8,512		8,512		8,512			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,837	1,837		1,837		1,837			35
36	Other (specify):*											36
37	TOTAL Ownership			221,642	221,642		221,642		221,642			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					24,000	24,000		24,000			39
40	Barber and Beauty Shops					283	283		283			40
41												41
42	Provider Participation Fee			130,005	130,005		130,005		130,005			42
43	Other (specify):* EXCEPTIONAL (CARE EXPENSI	ES			20,387	20,387		20,387			43
44	TOTAL Special Cost Centers			130,005	130,005	44,670	174,675		174,675			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,394,194	695,410	1,410,225	5,499,829		5,499,829	(6,165)	5,493,664			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

0000786

Report Period Beginning:

12/01/99

11/30/00 **Ending:**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	III Column	1	1	2	Ten the particula	T
			1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals		(1,752)	V2		4
5	Telephone, TV & Radio in Resident Rooms		(4,741)	V5		5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation					9
10	Interest and Other Investment Income					10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax					13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt		(18,228)	V27		24
25	Fund Raising, Advertising and Promotional					25
	Income Taxes and Illinois Personal					
26	Property Replacement Tax					26
27	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising					28
29	Other-Attach Schedule					29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(24,721)		\$	30

	OHF USE ONL	V				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	1		1		
		A	mount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$			31
32	Donated Goods-Attach Schedule*				32
	Amortization of Organization &				
33	Pre-Operating Expense				33
	Adjustments for Related Organization				
34	Costs (Schedule VII)		18,556		34
35	Other- Attach Schedule				35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	18,556		36
	(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$	(6,165)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

(Se	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		283	V5(3)	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		20,387	V10,V10a	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 20,670		47

Page 5A

VERMILION MANOR NURSING HOME

	ID#	0000786	
Report Period Beginning	g:	12/01/99	
Ending:		11/30/00	

Sch. V Line

NON-ALLOWABLE EXPENSES Amount Reference 1 S 1 1 2 C C C 3 3 C C C 3 4 C C C 6 5 C C C C 6 6 C C C C 6 6 C C C 6 6 C				Sch. V Line	
2 3 3 3 4 4 4 4 5 6 6 6 6 7 7 8 8 8 8 9		NON-ALLOWABLE EXPENSES	Amount	Reference	
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80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90	Total 0	90

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/99 Ending: 11/30/00 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	SUMMART OF TAGES 3, 3A, 0, 0F	1, 02, 00, 00,	02, 01, 03, 0										SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	1
	A. General Services	5 & 5A	6	6A	6B	6 C	6D	6E	6F	6 G	6Н	6 I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	4,169	0	0	0	0	0	0	0	0	0	4,169	18
19	Professional Services	0	3,500	0	0	0	0	0	0	0	0	0	3,500	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	6,200	0	0	0	0	0	0	0	0	0	6,200	21
	Employee Benefits & Payroll Taxes	0	4,687	0	0	0	0	0	0	0	0	0	4,687	22
	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	18,556	0	0	0	0	0	0	0	0	0	18,556	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	18,556	0	0	0	0	0	0	0	0	0	18,556	29

Summary B **VERMILION MANOR NURSING HOME** 12/01/99 Ending: 11/30/00 Facility Name & ID Number # 0000786 **Report Period Beginning:**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col.	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	18,556	0	0	0	0	0	0	0	0	0	18,556	45

0000786

Report Period Beginning:

12/01/99

Page 6 Ending: 11/30

11/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Litter below the names of ALL C	Wilers and rei	ated organiz	organizations (parties) as defined in the instructions. Attach an additional schedule in necessary.						
1		2			3				
OWNERS	RELATED NURSING HOMES			OTHER RELATED BUSINESS ENTITIES					
Name	Ownership %	Name		City		Name		City	Type of Business
N/A		N/A		NAME OF THE OWNER,		VERMILION	D	ANVILLE	COUNTY
				10.00		COUNTY			GOV'T

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V		NURSING HOME	\$			\$	\$	1
2	V	18	COMMITTEE		VERMILION COUNTY	N/A	4,169	4,169	2
3	V	19	AUDIT		VERMILION COUNTY	N/A	3,500	3,500	3
4	V	21	ACCOUNTING/PAYROLL		VERMILION COUNTY	N/A	6,200	6,200	4
5	V	22	GROUP INSURANCE		VERMILION COUNTY	N/A	4,687	4,687	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 18,556	\$ * 18,556	14

 $[\]mbox{\ensuremath{^{*}}}$ Total must agree with the amount recorded on line 34 of Schedule VI.

11/30/00

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hour	rs Per Work				
					Compensation	Week Devo	ted to this	Compensation	on Included	Schedule V.	
					Received	Facility and % of Total		in Costs	for this	Line &	1
				Ownership	From Other	Work Week		Reportin	g Period**	Column	1
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	l
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STA	TE	OF	ш	INO
		\ / I '		

OIS Page 8 0000786 Report Period Beginning: **Facility Name & ID Number VERMILION MANOR NURSING HOME** 12/01/99 **Ending:** 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

		Name of Related Organization	VERMILION COUNTY, IL
A. Are there any costs included in this report which were	derived from allocations of central office	Street Address	6 N. VERMILION
or parent organization costs? (See instructions.)	YES X NO	City / State / Zip Code	DANVILLE, IL. 61832
		Phone Number	(217) 431-2553

B. Show the allocation of costs below. If necessary, please attach worksheets.

City / State / Zip Code	DAITVILLE, IL. 01052
Phone Number	(217) 431-2553
Fax Number	(217) 431-6714

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1		NURSING HOME COMMITTEE		1		\$ 4,169	\$	1	\$ 4,169	1
2		AUDIT		1		3,500		1	3,500	2
3		ACCOUNTING/PAYROLL		1		6,200		1	6,200	3
4	22	GROUP INSURANCE		1		4,687		1	4,687	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 18,556	\$		\$ 18,556	25

VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/01/99

Ending:

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	_	3	4	5	6	7	8	9	10											
	Name of Lender	Related** YES NO												Purpose of Loan	Monthly Payment Required	Date of Note	Amo Original	ınt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related	1123	110		Required	11010	Original	Datanec		(T Digits)	Expense											
	Long-Term																					
1	9						\$	\$			\$	1										
2												2										
3												3										
4												4										
5												5										
	Working Capital																					
6	LOAN FROM COUNTY	X		OPERATING EXPENSES	N/A	1/01/97	200,000	183,384	N/A	0.0400	8,512	6										
7												7										
8												8										
9	TOTAL Facility Related B. Non-Facility Related*						\$ 200,000	\$ 183,384			\$ 8,512	9										
10												10										
11												11										
12												12										
13												13										
14	TOTAL Non-Facility Related						\$	s			\$	14										
15	TOTALS (line 9+line14)						\$ 200,000	\$ 183,384			\$ 8,512	15										

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued) B. Real Estate Taxes

B. Real Estate Taxes		
1. Real Estate Tax accrual used on 1999 report.	\$ <u>N/A</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment	t covers more than one year, detail below.) \$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).	\$ N/A	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the	e lines below.) \$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or othe (Describe appeal cost below. Attach copies of invoices to support the cost and		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining ref TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the state of the copy of t		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 through	6. \$ N/A	7
Real Estate Tax History:		
Real Estate Tax Bill for Calendar Year: 1995 N/A 8	FOR OHF USE ONLY	
1996 N/A 9 1997 N/A 10	13 FROM R. E. TAX STATEMENT FOR 1999 \$	13
1998 N/A 11 1999 N/A 12	14 PLUS APPEAL COST FROM LINE 5 \$	14
	15 LESS REFUND FROM LINE 6 \$	15
- - 	16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.

 This denial must be no more than four years old at the time the cost report is filed.

	ity Name & ID Number VERMILION			# 0000786	Report Period Be	ginning:	12/01/99 Ending:	11/30/00
X. BU	UILDING AND GENERAL INFORMA	ATION:						
A.	Square Feet: 74,800	B. General Construction Type:	Exterior	BRICK	Frame SING	LE STORY	Number of Stories	ONE
C.	Does the Operating Entity?	X (a) Own the Facility	(b) Rent from	a Related Organization	•		(c) Rent from Completely Unre Organization.	lated
	(Facilities checking (a) or (b) must co	omplete Schedule XI. Those checking (c) may complete Schedule	e XI or Schedule XII-A.	See instructions.)		 	
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equip	ment from a Related O	rganization.		(c) Rent equipment from Comp Unrelated Organization.	oletely
	(Facilities checking (a) or (b) must co	omplete Schedule XI-C. Those checking	(c) may complete Sched	ule XI-C or Schedule X	II-B. See instructio	ons.)	ometated organization.	
Е.	(such as, but not limited to, apartmen	by this operating entity or related to the nts, assisted living facilities, day training uare footage, and number of beds/units	g facilities, day care, ind	ependent living facilitie				
								-
F.	Does this cost report reflect any orga If so, please complete the following:	nnization or pre-operating costs which a	re being amortized?		YF	ES X	NO	
1.	. Total Amount Incurred:			2. Number of Years O	ver Which it is Bei	ng Amortized:		
3.	. Current Period Amortization:			4. Dates Incurred:				
		Nature of Costs: (Attach a complete schedule det	ailing the total amount o	of organization and pre-	operating costs.)			
VI O	NAMED CHID COCTO							
XI. C	OWNERSHIP COSTS:	1	2	3	4			
	A. Land.	Use	Square Feet	Year Acquired	Cost	:	\neg	
		1 INFORMATION NOT AV	/AILABLE		\$	1		
						2		

3 TOTALS

STATE OF ILLINOIS

0000786 Report Period Beginning:

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0000786

12/01/99 Ending:

Facility Name & ID Number

VERMILION MANOR NURSING HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ng Depreciation-Including Fixed Equ	2	3		4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year			Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	150		1974	1974	\$	2,290,108	\$ 57,253	40	\$ 57,253	\$	\$ 1,536,270	4
5	87		1979	1979		1,961,500	49,038	40	49,038		1,049,614	5
6												6
7												7
8												8
	Impro	ovement Type**										
9	CONSTRUC	TION		1980		92,111	2,303	40	2,303		48,361	9
		OT/GARAGE		1980		16,200		10			16,200	10
	FINAL CON	STRUCTION		1981		6,000	150	40	150		3,000	11
	ROOF			1982		40,042		10			40,042	12
	PUMP			1982		9,414		10			9,414	13
	ROOF			1983		39,569		10			39,569	14
	ROOF			1984		52,663		10			52,663	15
	WATER HEA			1985		27,463		10			27,463	16
	DRIVEWAY			1985		4,200		10			4,200	17
	WATER LIN	E		1986		5,290		10			5,290	18
	FENCE			1986		609		10			609	19
	LINT CATC			1986		5,981		10			5,981	20
	PARKING L			1986		26,927		10			26,927	21
	ROOF/DUCT			1986		6,114		10	701		6,114	22
	CANOPY RE	PAIR		1988		12,075	604	20	604		7,547	23
	RUB RAILS	W 170		1988		2,821	141	20	141		1,775	24
	CERAMIC T			1988		6,872	344	20	344		4,212	25
		K/COMPUTER		1988		2,030	101	20	101		1,234	26
		TAL CONDITIONER		1988		17,116	856	20	856		10,270	27
	WATER ME 400 AMP LIN			1988		1,457	97 170	15 20	97 170		1,166	28 29
				1988		3,400					2,139	
	AIR CONDIT			1989 1989		146,368 1,763	7,318 88	20 20	7,318 88		76,594 1,028	30
		TIONER UNITS		1989		21,470	1,074	20	1,074		1,028	31
				1990		4,589	229	20	229		2,447	33
	HOT WATER STORAGE TANK BUILDING IMPROVEMENT					18,139	907	20	907		9,750	34
	35 ROOF REPAIR					10,500	525	20	525		5,163	35
	TOTAL (lin			1991	©	4,832,791	\$ 121,198	20	\$ 121,198	\$	\$ 3,006,419	36
30	IJJIAL (IIII	cs 4 un u 33)			Ф	4,034,771	D 141,170		p 141,170	Φ	J,000,419	30

^{*}Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 0000786 **Report Period Beginning:** 12/01/99 Ending: 11/30/00

Facility Name & ID Number

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

VERMILION MANOR NURSING HOME

	1	ing Depreciation-including Fixed Equip	2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impr	ovement Type**	•								
9	FIRE HYDR	ANT		1991	2,185	109	20	109		1,073	9
10	PUMPS			1991	1,700	85	20	85		829	10
11	AIR CONDI	ΓΙΟΝΕR		1991	9,217	461	20	461		4,340	11
12	FIRE DOOR	S AND RELATED IMPROVEMENTS		1991	4,354	218	20	218		1,991	12
13	PLUMBING			1991	7,162	358	20	358		3,252	13
14	AIR HANDL	ER/CORNER GUARDS		1991	4,028	201	20	201		1,813	14
15	GENERATO	R		1992	70,808	3,540	20	3,540		30,611	15
	PLUMBING			1992	62,884	3,144	20	3,144		27,136	16
	AIR CONDI			1992	24,201	1,210	20	1,210		10,139	17
	LIGHT FIXT			1992	1,395	70	20	70		593	18
19	ROOF REPA	AIRS		1993	38,982	1,949	20	1,949		14,522	19
	WALK-IN F			1993	11,400	570	20	570		4,370	20
		'ATION IMPROVEMENTS		1993	3,215	214	15	214		1,607	21
22	SMOKING F	ROOM		1993	6,511	326	20	326		2,415	22
23	LOUNGE W			1993	1,004	50	20	50		364	23
		MPROVEMENTS		1993	9,952	498	20	498		3,629	24
		WATER HEATER		1994	5,987	299	20	299		1,995	25
	ACTIVATO	R PARTS		1994	1,190	59	20	59		396	26
	DAMPERS			1994	3,082	154	20	154		989	27
	CALL SYST	EM		1994	3,427	171	20	171		1,028	28
	GARAGE			1994	13,254	663	20	663		3,976	29
	ROOFING			1994	38,981	1,949	20	1,949		11,694	30
	BOOSTER H			1995	4,320	432	10	432		2,484	31
	CALL LIGH			1995	3,577	358	10	358		2,027	32
	FOLDING PARTITION			1995 1995	4,880	488	10	488		2,440	33
	REWIRE GARAGE				650	33	20	33		163	34
		WORK DRIVEWAYS	1996	10,170	678	15	678		2,938	35	
36	TOTAL (lin	es 4 thru 35)			\$ 348,516	\$ 18,287		\$ 18,287	\$	\$ 138,814	36

^{*}Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

0000786 **Report Period Beginning:** 12/01/99 Ending:

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11/30/00

Facility Name & ID Number

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

VERMILION MANOR NURSING HOME

	1	ing Depreciation-including Fixed Equ	2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		ovement Type**	•								
	EXHAUST S			1996	5,346	535	10	535		2,629	9
10	CONCRETE	WORK-FRONT ENTRANCE		1996	1,050	70	15	70		309	10
	CANOPY			1996	19,619	1,308	15	1,308		5,450	11
	TILE REPLA			1996	1,128	113	10	113		452	12
	ROOF REPA			1997	30,645	1,532	20	1,532		5,235	13
	AIRCONDIT			1997	15,322	766	20	766		2,490	14
	DRIVEWAY			1997	2,900	290	10	290		967	15
	WATER HE			1998	6,200	620	10	620		1,395	16
		MPROVEMENT		1998	1,013	101	10	101		202	17
	ROOF REPA			1998	21,809	2,181	10	2,181		4,544	18
		FIONER UNITS		1998	9,160	458	20	458		954	19
		FIONER UNITS		1998	8,580	429	20	429		858	20
		FIONING UNITS		1999	49,921	2,496	20	2,496		3,328	21
	CANOPY RI	EPAIR		1999	7,630	382	20	382		477	22
	NEW ROOF			1999	22,973	1,149	20	1,149		1,532	23
	GENERATO			2000	7,951	232	20	232		232	24
	WATER HE			2000	8,368	139	20	139		139	25
	CONDENSE	R		2000	2,350	29	20	29		29	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34 35
35	TOTAL O'	4 41 25)			0 221.075	a 12 020		a 12.020	Φ.	e 21 222	
36	IUTAL (lin	es 4 thru 35)			\$ 221,965	\$ 12,830		\$ 12,830	\$	\$ 31,222	36

^{*}Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Page 13 **Facility Name & ID Number VERMILION MANOR NURSING HOME** 0000786 **Report Period Beginning:** 12/01/99 11/30/00 **Ending:**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
37	Purchased in Prior Years	\$ 412,282	\$ 53,037	\$ 53,037	\$	VARIOUS	\$ 292,680	37
38	Current Year Purchases	16,082	1,482	1,482		VARIOUS	1,482	38
39	Fully Depreciated Assets	475,586				VARIOUS	475,586	39
40								40
41	TOTALS	\$ 903,950	\$ 54,519	\$ 54,519	\$		\$ 769,748	41

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
42	RESIDENT TRANS	DODGE VAN 1989	1989	\$ 25,461	\$	\$	\$	5	\$ 25,461	42
43	RESIDENT TRANS	FORD VAN 1996	1996	22,296	4,459	4,459		5	19,323	43
44	MAINTENANCE	FORD TRUCK 1993	1993	19,169				5	19,169	44
45										45
46	TOTALS			\$ 66,926	\$ 4,459	\$ 4,459	\$		\$ 63,953	46

E. Summary of Care-Related Assets

	•	Reference	Am	ount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	6,374,148	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	211,293	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	211,293	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$		50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$	4,010,156	51

1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

- Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
- This must agree with Schedule V line 30, column 8.

						STA	TE OF ILLINOIS	S					Page 14
Faci	lity Name & II	D Number	VERMILION MAN	OR NURSING H	OME	#	0000786	Re	port Period	Beginning:	12/01/99	Ending:	11/30/00
XII.	 Name of I Does the f 	nd Fixed Equ Party Holding	ay real estat <mark>e taxes in addi</mark>		ount shown below	on line 7	7, column 4? YES]NO		-			
		1	2	3	4		5	6]			
		Year	Number	Date of	Rental		Total Years	Total Yea					
-	Original	Constructo	ed of Beds	Lease	Amount		of Lease	Renewal Opt	tion^	10 Effortiv	e dates of curren	t wantal agrees	mant.
3	Building:			•					3		g	U	ment.
4	Additions	-		4					4	Ending	s		
5									5	_			
6									6	11. Rent to	be paid in future	years under t	he current
7	TOTAL			\$					7	rental a	greement:		
	This amou		ortization of lease expense lated by dividing the total use							12.	/2001 /2002	Annual Ros	ent
	9. Option to	Buy:	YES	NO Tern	ıs:		*			14.	/2003	\$	
	15. Îs Moval	ble equipment	Transportation and Fixed trental included in building ovable equipment:	Equipment. (See ng rental?	nstructions.) Description	n: COP	Y MACHINES L			LON FIRST of movable equipi	nent)		
	C. Vehicle Re	ental (See inst	ructions.)										
	1		2	7.5	3		4						
	Use		Model Year and Make		thly Lease syment		Rental Expense for this Period			* If the	re is an option to	huy the huildi	nσ
17	USC		anu Marc	\$	iyinciit	\$	101 1115 1 11100	17			provide comple		
18								18		sched			
19								19					
20								20		** This a	mount plus any	<u>amortization o</u>	<u>of lease</u>

21 TOTAL

21

please provide complete details on attached schedule.

^{**} This amount plus any amortization of lease expense must agree with page 4, line 34.

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Page 15 11/30/00 **VERMILION MANOR NURSING HOME** 0000786 **Report Period Beginning:** 12/01/99 **Ending: Facility Name & ID Number**

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

	YPE OF TRAINING PROGRAM (If aides are train	`	,	schedule listing t	he facility name	e, address and cost per aide trained in that facility.)
	1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES 2	. <u>CLASSROOM</u>	PORTION:		3. <u>CLINICAL PORTION:</u>
	PERIOD?	X NO	IN-HOUSE PR	ROGRAM		IN-HOUSE PROGRAM
	If "year" places complete the name index		IN OTHER FA	ACILITY		IN OTHER FACILITY
	If "yes", please complete the remainder of this schedule. If "no", provide an		COMMUNITY	COLLEGE		HOURS PER AIDE
	explanation as to why this training was not necessary.		HOURS PER	AIDE		
В. Е	XPENSES	ALLOCATI 1	ON OF COSTS	(d) 3		C. CONTRACTUAL INCOME In the box below record the amount of income your facility received training aides from other facilities.
		Fa	cility	1 		Tacinty received training andes from other facilities.
		Drop-outs	Completed	Contract	To	tal S
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					D. NUMBER OF AIDES TRAINED
3	Classroom Wages (a)					
4	Clinical Wages (b)					COMPLETED
5	In-House Trainer Wages (c)					1. From this facility
6	Transportation					2. From other facilities (f)
7	Contractual Payments					DROP-OUTS
8	Nurse Aide Competency Tests					1. From this facility
9	TOTALS	\$	\$	\$	\$	2. From other facilities (f)

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Ending:

Page 16 11/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

8 2 5 6 7 Schedule V **Outside Practitioner Supplies** Staff Line & Column Units of (Actual or) **Total Units Total Cost** Cost (other than consultant) Service Reference Service Units (Column 2 + 4)(Col. 3 + 5 + 6)Cost Allocated) **Licensed Occupational Therapist** hrs **Licensed Speech and Language Development Therapist** hrs **Licensed Recreational Therapist** 3 hrs **Licensed Physical Therapist** hrs **LINE 39(8) Physician Care** 24,000 52 24,000 5 visits **Dental Care** visits 6 **Work Related Program** hrs Habilitation hrs 8 # of **Pharmacy** prescrpts **Psychological Services** (Evaluation and Diagnosis/ **Behavior Modification)** hrs 10 **Academic Education** 11 hrs **Exceptional Care Program** 12 13 Other (specify): 13 14 TOTAL 24,000 **52** \$ 24,000

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

11/30/00

(last day of reporting year)

As of

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

		1		2 After	
	A Comment Assets	0	perating	Consolidation*	
1	A. Current Assets Cash on Hand and in Banks	\$	394,424	S	1
2	Cash-Patient Deposits	Φ	40,239	Ψ	2
	Accounts & Short-Term Notes Receivable-		40,237		
3	Patients (less allowance 50,000)		731,328		3
4	Supply Inventory (priced at)		751,520		4
5	Short-Term Investments				5
6	Prepaid Insurance	1			6
7	Other Prepaid Expenses	1			7
8	Accounts Receivable (owners or related parties)	1			8
9	Other(specify):	1			9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,165,991	\$	10
	B. Long-Term Assets		, ,		
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land				13
14	Buildings, at Historical Cost		5,384,603		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		989,545		16
17	Accumulated Depreciation (book methods)		(4,010,156)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	2,363,992	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	3,529,983	\$	25

		1 0	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	134,509	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		47,443		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		151,304		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	DUE TO OTHER FUNDS		487,324		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	820,580	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43	3 (1 1/				43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES	Ė			+
46	(sum of lines 38 and 45)	\$	820,580	\$	46
	(sum of times to unu 10)	Ψ	020,000	Ψ	+
47	TOTAL EQUITY(page 18, line 24)	\$	2,709,403	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	3,529,983	\$	48

*(See instructions.)

Report Period Beginning: 12/01/99 0000786

Page 18 11/30/00

Ending:

			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	2,815,661	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	2,815,661	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(106,258)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(106,258)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	2,709,403	24

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

Gros	TOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$ (\$	5,332,882	1 2 3 3 4 5 6 7
Gros	ss Revenue All Levels of Care counts and Allowances for all Levels ETOTAL Inpatient Care (line 1 minus line 2) Ancillary Revenue Care er Care for Outpatients rapy //gen ETOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$)	3 3 4 5 6 7
B. A Day	Ancillary Revenue ' Care er Care for Outpatients rapy //gen BTOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements		5,332,882	3
B. A Day Othe Ther Oxyg SUB C. O Payn Othe Nurs Gift Barb Non- Tele Rent Rent Rent Rent Rent Sale Radi Othe Laur SUB Laur SUB Laur SUB Laur SUB Laur SUB Laur SUB	Ancillary Revenue Care or Care or Care for Outpatients rapy Gen BTOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education or Government Grants ses Aide Training Reimbursements		5,332,882	4
4 Day 5 Othe 6 Ther 7 Oxy 8 SUB 6 C. O 9 Payn 0 Othe 1 Nurs 2 Gift 3 Barb 4 Non- 5 Tele 6 Rent 7 Sale 8 Sale 9 Labo 1 Othe 1 Othe 1 D. N 4 Cont 5 Inter 6 SUB	r Care er Care for Outpatients rapy //gen BTOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$		5
5 Othe 6 Ther 7 Oxyg 8 SUB 7 C. O 9 Payn 0 Othe 1 Nurs 2 Gift 3 Barb 4 Non- 5 Tele 6 Rent 7 Sale 8 Sale 9 Labc 0 Radi 1 Othe 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB	er Care for Outpatients rapy /gen BTOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$		(
6 Ther 7 Oxyg 8 SUB C. O 9 Payn 0 Othe 1 Nurs 2 Gift 3 Barb 4 Non- 5 Tele 6 Rent 7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB	rapy /gen BTOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$		7
7 Oxyg 8 SUB C. O 9 Payn 0 Othe 1 Nurs 2 Gift 3 Barb 4 Non- 5 Tele 6 Rent 7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter	TOTAL Ancillary Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$,
SUB C. O Paym	Other Operating Revenue (lines 4 thru 7) Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$		
C. O Payn O Othe Nurs Cift Barb Non- Tele Rent Sale Radi Othe Laur SUB Libra SUB SUB SUB SUB SUB	Other Operating Revenue ments for Education er Government Grants ses Aide Training Reimbursements	\$		
 Payn Othe Nurs Gift Barb Non- Tele Rent Sale Labo Radi Othe Laur SUB Inter SUB 	ments for Education er Government Grants ses Aide Training Reimbursements			
 O Othe 1 Nurs 2 Gift 3 Barb 4 Non- 5 Tele 6 Rent 7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB 	er Government Grants ses Aide Training Reimbursements			
1 Nurs 2 Gift 3 Barb 4 Non- 5 Tele 6 Rent 7 Sale 8 Sale 9 Labc 0 Radi 1 Othe 2 Laur 3 SUB' D. N 4 Cont 5 Inter 6 SUB'	ses Aide Training Reimbursements			
2 Gift 3 Barb 4 Non- 5 Tele 6 Rent 7 Sale 8 Sale 9 Labc 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB				1
3 Barb 4 Non- 5 Telep 6 Rent 7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter				1
4 Non- 5 Telep 6 Rent 7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB	and Coffee Shop			1
5 Telej 6 Rent 7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter	ber and Beauty Care			1
6 Rent 7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter	n-Patient Meals		1,752	1
7 Sale 8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter	ephone, Television and Radio			1
8 Sale 9 Labo 0 Radi 1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB	tal of Facility Space			1
9 Labo 10 Radi 11 Othe 2 Laur 13 SUB 14 Cont 15 Inter 16 SUB	e of Drugs			1
0 Radi 1 Othe 2 Laur 3 SUB' D. N 4 Cont 5 Inter 6 SUB'	e of Supplies to Non-Patients			1
1 Othe 2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB	oratory			1
2 Laur 3 SUB D. N 4 Cont 5 Inter 6 SUB	iology and X-Ray			2
3 SUB D. N C. 4 Cont C. 5 Inter C. 6 SUB C. 6 SUB C. 7 SU	er Medical Services			2
D. N4 Cont5 Inter6 SUB	ndry			2
D. N4 Cont5 Inter6 SUB	STOTAL Other Operating Revenue (lines 9 thru 22) \$	1,752	2
5 Inter	Non-Operating Revenue			
6 SUB	tributions			2
	rest and Other Investment Income***		23,623	2
	STOTAL Non-Operating Revenue (lines 24 and 25)	\$	23,623	2
LE. U	Other Revenue (specify):****		, ,	
7 Set				2
	ttlement Income (Insurance, Legal, Etc.)		35,314	2
8a	ttlement Income (Insurance, Legal, Etc.) CELLANEOUS	1	-)-	2
9 SUB	ttlement Income (Insurance, Legal, Etc.)		35,314	2

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	c against expense.	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,305,510	31
32	Health Care	3,105,490	32
33	General Administration	737,182	33
	B. Capital Expense		
34	Ownership	221,642	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	130,005	36
	D. Other Expenses (specify):		
37	• • • • • • • • • • • • • • • • • • • •		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,499,829	40
41	Income before Income Taxes (line 30 minus line 40)**	(106,258)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (106,258)	43

- * This must agree with page 4, line 45, column 4.
- * Does this agree with taxable income (loss) per Federal Income
 Tax Return? N/A If not, please attach a reconciliation.
- *** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number VERMILION MANOR NURSING HOME

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

3 4 # of Hrs. # of Hrs. Reporting Period Average Actually Paid and Total Salaries, Hourly Worked Accrued Wages Wage 1 Director of Nursing 1,938 2,104 40,982 19.48 2 Assistant Director of Nursing 1,755 1,896 36,043 19.01 2 3 Registered Nurses 24,899 26,244 472,751 18.01 3 4 Licensed Practical Nurses 52,040 699,269 4 48,722 13.44 5 Nurse Aides & Orderlies 106,539 114,807 1,024,969 8.93 6 Nurse Aide Trainees 6 7 Licensed Therapist 8 Rehab/Therapy Aides 8 9 Activity Director 1,921 2,113 19,816 9 9.38 10 Activity Assistants 8,956 10,373 69,544 6.70 10 11 Social Service Workers 5,462 5,889 46,783 7.94 11 12 12 Dietician 13 Food Service Supervisor 8,773 9,352 80,539 8.61 13 57,555 14 Head Cook 8,098 8,616 6.68 14 15 Cook Helpers/Assistants 15 31,581 33,903 236,624 6.98 16 Dishwashers 16 17 Maintenance Workers 17 8,342 103,093 11.57 8,909 18 Housekeepers 14,724 16,313 126,698 7.77 18 19 Laundry 11,766 12,953 92,289 7.12 19 56,200 20 Administrator 26.92 20 1,960 2,088 21 21 Assistant Administrator 1,022 1,097 8.87 9,735 22 22 Other Administrative 23 Office Manager 23 24 24 Clerical 14,091 15,309 115,448 7.54 25 Vocational Instruction 25 26 Academic Instruction 26 27 27 Medical Director 28 Qualified MR Prof. (QMRP) 28 29 29 Resident Services Coordinator 1,971 2,219 34,475 15.54 30 Habilitation Aides (DD Homes) 30 6,762 7,395 71,381 9.65 31 Medical Records 31 32 32 Other Health Care(specify) 33 Other(specify) 33 34 **TOTAL** (lines 1 - 33) 309,282 333,620 3,394,194 10.17

B. CONSULTANT SERVICES

_,		1	2	3	
		Number	Number Total Consultant		
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 17,410	1/3	35
	Medical Director				36
37	Medical Records Consultant		3,310	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,600	10/3	39
	Physical Therapy Consultant		5,913	10/3	40
	Occupational Therapy Consultant				41
	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
	Other(specify) FR & R		12,975	19/3	46
	COMPUTER SUPPORT		4,115	21/3	47
48	CLIFTON GUNDERSON LLP		175	19/3	48
49	TOTAL (lines 35 - 48)		\$ 46,498		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	179	\$ 6,416	10/3	50
51	Licensed Practical Nurses	617	18,377	10/3	51
52	Nurse Aides	1,156	19,432	10/3	52
53	TOTAL (lines 50 - 52)	1,952	\$ 44,225		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

Page 21 Ending: 11/30/00 STATE OF ILLINOIS VERMILION MANOR NURSING HOME **Report Period Beginning:** 12/01/99 # 0000786

					e of illinois			rage 21
	VERMILION MAN	OR NURSIN	G HOME	#_00007	786	Report Period I	Beginning: 12/01/99 Er	nding: 11/30/00
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries	.	Ownership		D. Employee Benefits and P			F. Dues, Fees, Subscriptions and Pro	
Name	Function	%	Amount	Descrip		Amount	Description	Amount
EDIE HESSER	ADMINISTRATOR		\$ 56,200	Workers' Compensation Ins		\$ 51,776	IDPH License Fee	\$
				Unemployment Compensati	on Insurance	3,034	Advertising: Employee Recruitment	
				FICA Taxes		252,917	Health Care Worker Background C	
				Employee Health Insurance		69,242	·	914
		<u> </u>		Employee Meals		27,375	BOOKS & PERIODICALS	3,667
				Illinois Municipal Retiremen	nt Fund (IMRF)*	84,402	DUES & FEES	7,458
				EMPLOYEE PHYSICALS		1,664		
TOTAL (agree to Schedule V, lin	ne 17. col. 1)			GROUP LIFE INSURANCE		4,687		
(List each licensed administrator	,		\$ 56,200	EMPLOYEE ASSISTANCE		4,500		
B. Administrative - Other	separately ty		+ + + + + + + + + + + + + + + + + + + 		1110 0111111			
b. Mullimstrative - Other							Less: Public Relations Expense	
Description			Amount				Non-allowable advertising	— <u>;</u> ——:
Description			Amount				9	— } ——:
			5				Yellow page advertising	(
				TOTAL	X 7	o 400 505	TOTAL (CLV	0 12 020
				TOTAL (agree to Schedule	ν,	\$ <u>499,597</u>	TOTAL (agree to Sch. V	, \$ <u>12,039</u>
				line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V, lin			\$	E. Schedule of Non-Cash Co	mpensation Paid		G. Schedule of Travel and Seminar*	*
(Attach a copy of any manageme	nt service agreement	t)		to Owners or Employees				
C. Professional Services							Description	Amount
Vendor/Payee	Type		Amount	Description	Line#	Amount		
FR & R	MEDICARE		\$			\$	Out-of-State Travel	\$
	CONSULT		12,975					
CLIFTON GUNDERSON LLP	ACCOUNTING					-		
CERT TOTA GET (BETTSOT) EET	CONSULT		175				In-State Travel	
	CONSULT						In-State Travel	
							-	
							Seminar Expense	
							Entertainment Expense	_ (
							Enter tallinent Expense	\
TOTAL (agree to Schedule V, lin	ne 19, column 3)			TOTAL		\$	(agree to Sch. V,	

^{*} Attach copy of IMRF notifications

^{**}See instructions.

#

Report Period Beginning: 12/01/99

Ending:

Page 22 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful	EV/1007	EX/1000	EV/1000	EN/2000	EW2001	EW2002	EN/2002	E3/2004	EW2005
<u> </u>	Туре	Was Made		Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

	y Name & ID Number VERMILION MANOR NURSING HOME	#	0000786	Report Period Beginning:	12/01/99	Ending:	11/30/00
	ENERAL INFORMATION:						-
(1)	Are nursing employees (RN,LPN,NA) represented by a union? YES, EXCEPT RN'S	(13)	the Department of Pu	oplies and services which are of the ablic Aid, in addition to the daily ra			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.		in the Ancillary Sect		_		
(3)	Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A	(14)	the patient census lis is a portion of the bu	ilding used for any function other ted on page 2, Section B? NO ilding used for rental, a pharmacy, plains how all related costs were al	day care, etc.)	For example If YES, attack	e,
	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A	(15)	Indicate the cost of e on Schedule V. related costs?		ssified to empl meal income b the amount. \$	een offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? YES 7	(16)	Travel and Transport	ation luded for out-of-state travel?	NO		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,421 Line 10		If YES, attach a co	omplete explanation. arate contract with the Department If YES, please indicate the a	t to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.		program during the c. What percent of al	is reporting period. \$ N/A I travel expense relates to transport e logs been maintained? YES			
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease. NO N/A		e. Are all vehicles sto times when not in	ored at the nursing home during the			
(9)	Are you presently operating under a sublease agreement? YES X NO		out of the cost repe	ort? N/A v transport residents to and from			NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		Indicate the am	ount of income earned from p during this reporting period.	roviding sucl	h N/A	
		(17)		rformed by an independent certifie FTON GUNDERSON LLP	ed public accou		YES tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 130,005 This amount is to be recorded on line 42 of Schedule V.			at a copy of this audit be included	with the cost re		is copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.	(18)	Have all costs which out of Schedule V?	do not relate to the provision of lo YES	ong term care b	een adjusted o	out
		(19)	performed been attac	in excess of \$2500, have legal involved to this cost report? N/A a summary of services for all archives			rices

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